MONTANA LEGISLATIVE BRANCH

Legislative Fiscal Division

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MINUTES
HJR 35 SUBCOMMITEE

Thursday & Friday, January 20, & 21, 2000
Helena, Montana

The third meeting of the House Joint Resolution (HJR 35) subcommittee was called to order by Senator Chuck Swysgood, Chairman, on January 20, 2000 at 8:30 a.m., in Room B-7 of the Federal Building. The following HJR 35 members were present:

Senator Swysgood, Chairman	Representative Taylor, Vice-Chairman
Senator Waterman	Representative McCann
Senator Franklin	Representative Barnhart

Senator Keenan and Representative Soft were excused.

Approval of Minutes

Senator Waterman moved that the minutes of the October 6, 1999, meeting be approved as presented. The motion carried unanimously.

Summary of Dr. Ira Lourie's Presentation

Dr. Ira Lourie, a child psychiatrist, has been working for the last two years in Montana to develop systematic approaches to children and adolescents with severe emotional disturbances and their families. In 1980 while Dr. Lourie served as Medical Director of the Regional Institute for Children and Adolescents (RICA) he learned that many children with mental health problems were being taken care of by other public systems. In 1983 Dr. Lourie worked at the National Institute of Mental Health (NIMH) where he was instrumental in the development and administration of the Child and Adolescent Service System Program (CASSP). CASSP was started in Montana in 1988 to serve severely mentally disturbed children and adolescents.

Four things were identified by a group of child mental health professionals from various states to build a total system of care for children. They are: 1) create an inter-agency process for children in other systems; 2) increase resources and create a state mental health system for children; 3)

create a family presence within the system of care; and 4) create a system that is culturally competent.

Dr. Lourie conducted a study on what the private sector had learned from the public sector about inter-agency systems and new techniques for meeting children's needs. He found that the principles created by CASSP and the principles for managed care were exactly the same. If a managed care program is adequately funded and allowed to buy any service it wants, not only could it save money, but it could get children the best service.

Managing Resources Montana (MRM) was created as a managed care program. Under MRM all the money went to community mental health centers and there was no incentive for those centers to bring in other providers. The community mental health centers weren't providing an array of services or creating new community based services and a utilization management gatekeeper was keeping children out of the highest level of care. Most states that went into managed care only put the low-level traditional mental health services in managed care.

MRM was successful in some regions, however, the success was not generalized across the state and the state's vision of a more efficient and effective system of care was not achieved. The Mental Health Access Plan (MHAP) was the next step in moving toward this vision. MHAP was instituted in April 1997 and, because of a number of serious problems, ended in June 1999.

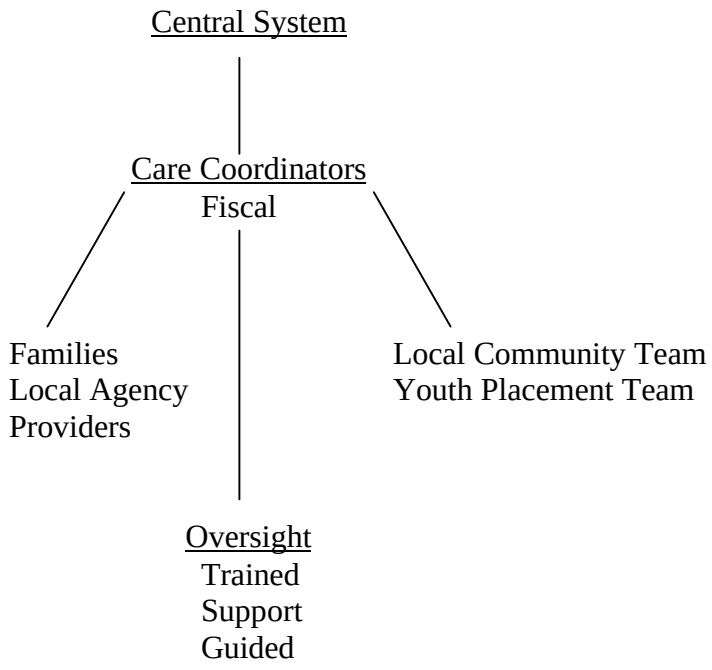
Dr. Lourie reviewed the positive outcomes of the state's venture into the mental health managed care contract with Magellan Behavioral Health Services and encouraged the Department of Public Health and Human Services to retain the advances accomplished by MHAP in public mental health services. (Exhibit 1) Those are:

- development and advancement of an enhanced vision of mental health service in Montana;
- emergence of a single mental health authority responsible for delivering mental health services for children;
- greater system of accountability in requiring a review of available community services prior to placement in higher end care;
- required patient discharge planning;
- improved access to services for seriously emotionally disturbed children by raising the income eligibility to 200 percent of the federal poverty limit;

- broad definition of seriously emotionally disturbed (SED) should be retained, however, it should consist of two levels: high-level SED and low-level SED;
- continuation of youth case management under the state SED definition, however, the categories of SED need to be refined to include more categories with various reimbursement rates;
- improved access to case management to coordinate and organize services;
- greater degree of flexibility in funding appropriate mental health services; and
- development of new community based services, particularly growth in school-based and rural services.

The child mental health system needs to consist of the following:

1) Strong central system
    a) Inter-agency coordination
    b) Strong mental health authority
        i) oversight
        ii) rate setting
        iii) policy function
        iv) technical assistance
        v) total support



Dr. Lourie also noted that coordination of public mental health services for children needs to be a unique solution for each community. He said that child mental health service planning is an extremely complicated process because it can involve several agencies. A successful process needs structure and authority from the state level and the flexibility to create unique approaches at the local level, which reflect the nature, resources, and sophistication of each community and region.

Standing Agenda Items

PACT update - Dan Anderson, Administrator, Addictive and Mental Disorders Division, Department of Public Health and Human Services, (Department) reported on the PACT Program. Both Helena and Billings PACT programs took 12 patients each from the Montana State Hospital (MSH) starting December 1, 1999. The Department found that taking 12 patients into each community in 1 month was too rapid of an increase. All of the patients from the MSH needed a place to live and to be integrated into the community, which was extremely time consuming. One of the patients in the Helena program has returned to MSH. The Department will be sending 6 people to Wisconsin in February to look at well-developed PACT programs to continue the education process. Also, consultants will be reviewing the PACT programs in Helena and Billings.

Senator Waterman asked Mr. Anderson how rapidly the teams would be filled. Mr. Anderson stated that the contracts with the mental health center states that an additional 12 patients from MSH must be placed in each community by May 1.

Senator Swysgood asked Debra Dirkson if the MSH is familiar with the new program and do they prepare patients to go out into these communities. Ms. Dirkson, CEO, Montana State Hospital (MSH), stated that they are familiar with the program. The hospital has a transitional care unit set-up for patients who are ready to be discharged. The hospital also works with community providers to outline a discharge plan for the patients. The community providers meet with the patients and review the plan with them before they leave the hospital. The Helena patients visited Helena and were able to see the services before they left MSH. **Senator Swysgood** also asked if anyone from the hospital has visited the sites. Ms. Dirkson said that the Director of Treatment and Rehabilitation has gone to some of the staff meetings in both Billings and Helena.

Senator Swysgood asked Mr. Anderson if the start-up money was adequate. Mr. Anderson stated that it has been more expensive than anticipated. The Department will have to examine the centers overall to see what it is costing and the extent to which the rate is adequate. **Senator Swysgood** also asked how long from the time the individuals leave the hospital until they begin receiving SSI. Ms. Steinbeck responded that it depends on whether the patient has to have their SSI reinstated. It can take up to a year and half from the time they apply and when they are told they will be able to get SSI.

MSH population - Mr. Anderson referred to the report on the MSH (Exhibit 2). The year to date average daily population (ADP) through December was 162, which compares with 177 for the same period in fiscal year 1999. The 162 does not include the full impact of the PACT placements. Ms. Dirkson reported that as a result of the PACT programs the ADP on January 20 is 148 to date.

Senator Swysgood commented that although the ADP continues to drop, the hospital is still way above the 135. **Senator Swysgood** asked if there is a projection as to when the MSH will reach this number. Ms. Dirkson reported that the PACT teams are now taking patients out of the higher-end services which will make more group home beds available and 24 more patients will be discharged from the MSH into the PACT program May 1. The MSH should be below the ADP of 135 by May 1.

Representative McCann asked how many patients are waiting to get into the hospital. Ms. Dirkson stated that there are no patients currently waiting to be admitted to the hospital but they do have patients waiting to be discharged. **Representative McCann** also asked how many patients will not be able to leave the hospital because they will not be eligible for PACT. Ms. Dirkson stated that she believes all of the patients at some point will be able to leave the hospital but it will take some longer than others.

Senator Waterman asked if any of the psychiatric units of local hospitals closed would that increase MSH admissions. Mr. Anderson stated that that would definitely have an impact in increased admissions. **Senator Waterman** also asked why another contractor was being hired to complete work on the new MSH. Ms. Dirkson reported that some of the items to be completed are not in the contract specifications.

Senator Swysgood requested that someone from A&E attend the March meeting.

Expenditures compared to appropriation – Mr. Anderson referred to the handout on Budget & Expenditures FY 2000 (Exhibit 3). The Department's ability to project the Medicaid and mental health fee-for-service expenditures is very limited because they have nothing to compare it with. The only basis for projecting expenditures is comparing claims payment in relation to how quickly claims were paid under the previous Medicaid system There will be additional costs associated with the delay of the MSH project for which there is no funding source.

Senator Swysgood asked the Department when they would have data available to compare costs. Laurie Ekanger, Director, DPHHS, stated that the Department plans to visit with the Budget Office in the next 3 to 4 weeks. Ms. Ekanger reported that the Department has not had a budget status report all year because they didn't have numbers they were comfortable with. **Senator Swysgood** asked why they were not comfortable with the numbers. Mike Billings, Administrator, Operations and Technology Division stated that data from SABHRS has not been available in a form that the Department could use. The Department should have the data within the next 3 weeks. The agency reporting structure is extremely complex under SABHRS. **Senator Swysgood** requested that when the Department has the data that they make it available to the committee.

Oversight Advisory Council Recommendations/Actions – Mr. Anderson reported that there are no formal recommendations from the Oversight Advisory Council at this time. The Council has formed an executive committee that meets monthly. The members are Senator Keenan, Brian Garrity, Kathy Bailey, Kathy Caulker, Boyd Roth and Dan Anderson.

MHAP claims – Laurie Ekanger, reported that the reserve fund has been paid out. Bob Mullen, Chief, Operations Bureau, reported that MCP has paid approximately $6.4 million in claims for the month of May and approximately $6.0 million for the month of June. Claims for the month of May should be substantially complete.

Senator Swysgood asked how many contested claims still need to be addressed. Jacquelyn Lenmark, representative for Magellan, reported that it is likely that all claims have not been presented. Ms. Lenmark will prepare a report for the next meeting.

Senator Waterman asked if there is any liability to the state for any pending claims. Ms. Ekanger responded that liability for all claims during the time of the contract is the responsibility of Magellan. The state has liability for the claims Magellan processed for the Department for the months of May and June.

Mental Health Ombudsman Report

Bonnie Adee, Mental Health Ombudsman, gave a brief overview of her handout. (Exhibit 4) Items addressed were:

- Access to Services
- Service Adequacy
- Focus on Recovery
- Outcome measures
- Planning

Funding Public Mental Health Services

Lois Steinbeck, Senior Fiscal Analyst, Legislative Fiscal Division, gave a presentation on funding and eligibility for and access to state public mental health services. (Exhibit 5) Programs and funding sources that were specifically reviewed included Medicaid, the Mental Health Services Plan (MHSP), and the Children's Health Insurance Program (CHIP). Public mental health services are funded by state and local governments and local school districts. The 1999 Legislature appropriated approximately $98 million total funds specifically for mental health services.

Medicaid is the most significant public funding source for mental health services. Eligibility for Medicaid funded services is the most complex of the three major state funding sources and Medicaid has the most extensive array of services. Eligibility for Medicaid funded services is based on income and resources and both children and adults can be eligible.

MHSP, funded entirely by state general fund, is designed specifically for low-income adults with a severe and disabling mental illness and low-income children who are seriously emotionally disturbed. Eligibility for MHSP depends on income and diagnosis. MHSP services are generally comparable to those offered by Medicaid.

CHIP is a federal and state funded program and, also covers some mental health services for children in low-income families. CHIP eligibility is determined solely by income. CHIP has the least extensive array of mental health services of the three state funding sources.

Childless, able-bodied adults under age 65 are not usually eligible to receive services from any of the funding sources.

METNET

The Committee hosted a statewide METNET video teleconference to receive comment on the development of appropriate public mental health services. (Exhibit 6) Issues identified in public testimony included:

- low reimbursement rates and under utilization of crisis services;
- lack of a single point of entry and coordination of children's services when more than one agency is involved;
- desire to have Medicaid bills sent to consumers for review of accuracy and services received;
- a worry about expanding services without additional funding;
- extended Medicaid coverage for persons with disabilities who are recovered enough to go back to work;
- need for a mental health court;
- lack of transitional mental heath services for persons discharged from prison; and
- training for law enforcement officers in recognition of and working with mentally ill people.

Friday, January 21, 2000

The third meeting of the House Joint Resolution (HJR 35) subcommittee continued on Friday, January 21, 2000. Senator "Chuck" Swysgood, Chairman called the meeting to order at 8:10 a.m., in Room B-7 of the Federal Building.

The following HJR 35 members were present:

Senator Swysgood, Chairman	Representative Taylor, Vice-Chairman
Senator Franklin	Representative Barnhart

Senator Waterman, Senator Keenan, Representative McCann and Representative Soft were excused.

Provider Panel Discussion

Participants of the provider panel were: **Libby Artley**, Administrative Director, Deaconess Billings Clinic (Exhibit 7); **Linda Hatch**, Executive Director, Golden Triangle Community Mental Health Center (Exhibit 8); **Dr. Diane Zuniga**, Children's Unit Director, Shodair Children's Hospital; **Leo Hammond**, Executive Director Youth Dynamics Inc.; **Dr. Bob Bakko**, Executive Director, Northwest Counseling Centers, Inc.; **David Groot**, MSW, Director of Community Programs, Yellowstone Boys and Girls Ranch; **Larry Noonan**, Chief Executive Office AWARE, Inc. (Exhibit 9); **Jeff Krott**, Consumer Advocate (Exhibit 10).

Panelists noted several improvements in the state public mental health system, including significant improvements in communication and consistency in the program. The panel also identified several issues (Exhibit 11):

- high-end services, such as hospitals and residential care facilities for children, are full with waiting lists;
- difficulty in discharging persons when it is appropriate to do so;
- increasing lengths of stay for high-end services;
- some reimbursement rates are not adequate to cover the cost of services, especially due to increasing lengths of stay when rates are based on DRG's (diagnostically related group);
- some adults and children are entering high-end services without ever first receiving community based services that may have prevented hospitalization;
- fear of another major change in the mental health system, discouraging some providers from participating;
- lack of access to psychiatric care (generally seen as a statewide problem);
- lower census in some community-based services such as therapeutic foster care;
- reduction of some community-based services such as family-based services;
- lack of consumer-run alternatives;
- lack of meaningful, daily activities for mentally ill adults; and
- lack of a clear vision of what mental health services ought to be in Montana.

Senator Swysgood asked Ms. Artley why the patients they see are not being referred to lower costs services before coming to the hospital. Ms. Artley stated that there is a shortage of

psychiatrists and physicians. **Senator Swysgood** also asked if the situation is worse now than when it was under Magellan. Ms. Artley responded that it is not worse in terms of numbers of admissions in Billings, however, the length of stay has increased.

Representative Barnhart asked what is different from how the system was before managed care and how it works now and is something missing. Mr. Hammond responded that before managed care most lower level referrals came from DPHHS before they had gone to the point that they needed higher-end services. Because of budget constraints, managed care, etc., some children are not receiving care as early as they used to. Managed care has forced people to leave children in the home longer.

Senator Swysgood asked Mr. Noonan how much it would cost to keep transitional services functional. Mr. Noonan reported about $70.00 per day.

Randy Poulsen responded to Dr. Bakko's concerns regarding the uncertainty of the providers. Mr. Poulsen assured Dr. Bakko that the Department would not be rushing into a new payment system anytime soon. The Mental Health Oversight Advisory Council is charged with reviewing the way the Department is delivering services and paying for services. Mr. Poulsen is confident there won't be any recommendation for extensive change.

Mr. Poulsen reported that there have been no authorization requirements for outpatient services since July 1. Consultec has been trying to correct the problems caused by DataNet, a private contractor. The Department is willing to provide advance payments to any providers who have a cash flow problem.

Mr. Poulsen stated that the Department needs specific information on the misdirected denials that go to Consultect to isolate the confidentiality problem.

Senator Swysgood thanked the panel for presenting their concerns.

The subcommittee members toured the new Helena facility of the Golden Triangle Mental Health Center and had lunch with adults who receive services from the center.

Helena Youth and Family Initiative (Pilot Program)

Participants of the panel are: **Fred Fischer**, Casey Family Program; **Kathy Ostrander**, Helena Regional Administrator, Child Protective Services; **Dick Meeker**, Juvenile Probation Officer, First Judicial District; and **Joe Furshong**, Director Special Services, Helena Public Schools. (Exhibit 12)

The pilot project is a three year system of care in the Helena area testing the potential and the limitations of a unified service planning, coordinated care delivery, and collaborative funding model for ten families whose children have multi-agency needs. The goal of the project will be to maintain in their homes high-risk children with mental health needs who are involved with more than one agency. The project will directly involve families in helping to determine the kinds of services they believe they need. The pilot will be evaluated by a series of outcomes with specific measurements. The broad outcomes to be measured are:

- stable or improved behavior and functioning at home and in the community;
- ability to form and sustain consistent positive relationships with family and/or surrogate family;
- educational development;
- self sufficiency;
- legal involvement; and
- several competencies and achievements.

Senator Franklin asked what sort of resources would help other communities. Mr. Furshong responded that encouragement on part of the agencies at the central office level to work together through rules and funding structure. Also, the agencies need to create a de-categorized pool of funding with a flexible funding system, and a screening committee allowing access to funding.

Youth Service Committees

Susan Byorth Fox, Research Analyst, Legislative Services Division, referred to the handout Statutory "Teams" for Providing Youth Services (Exhibit 13). Statutory "Teams" identified are:

- child protective teams/interdisciplinary protective teams;
- youth placement committees;
- interagency cooperative agreements;

- county interdisciplinary child information team or an auxiliary team;
- multiagency service placement plan committee;
- foster care review committee; and
- local citizen review board.

Other "Teams"

For persons with developmental disabilities under the age 18 there are no statutory "teams". For a child with a disability a child study team is used to identify a child with a disability and teams are used to plan individual education programs. These teams are regulated under policies adopted by the Board of Public Education.

March Agenda

Senator Swysgood noted that the meetings following March will be work sessions and the committee will need to put together recommendations for the August LFC meeting.

Information and discussion on ICC, and flexible funding options and alternatives will be added to the March agenda. Ms. Steinbeck will provide written information on SSI. Mr. Poulsen will provide a follow-up report regarding the confidentiality issues and rates paid for masters in social work and psychiatrists.

Next HJR 35 Subcommittee Meeting

The next HJR 35 subcommittee meeting is set for Wednesday, March 8th. A tentative 2-day meeting is scheduled for May 10th and 11th.

Adjournment

Meeting adjourned at 2:55 p.m.

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Sen. Chuck Swysgood, Chairman

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Diane McDuffie, Committee Secretary